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ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION GUIDANCE AND INSTRUCTIONS FY 2006 - 2007

CFDA No. 93.958

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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Notice to Respondents

The annual reporting burden for collection of this information is estimated to average 315 hours for a one-year application, 285 hours for updating a two-year plan, and 254 hours for updating a three-year application. This includes the time required for reviewing instructions and preparing the application, requesting waivers and modifications, writing the implementation report, and gathering, maintaining, and reporting the needed data. Comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden should be addressed to: SAMHSA Reports Clearance Officer, Paperwork Reduction Project (0930-0168), Room 7-1045, One Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor or a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is: 0930-0168.

INTRODUCTION:

In FY 2000, Congress requested SAMHSA to present a report on transitioning both the mental health and substance abuse Block Grants to performance partnerships. The transition shifted the focus of required reporting from expenditures toward increased accountability based on quantitative performance measurement. For several years, CMHS has worked with the States to develop and enhance data collection systems to support this move toward accountability and performance measurement and elements of this work are included in this application. The FY 2006 – 2007 Community Mental Health Services Block Grant Application Guidance and Instruction Packet that follows is intended to provide a context for the FY 2006 – 2007 Application, and to provide specific guidance and instructions regarding the development and submission of the required plan.

While the FY 2005 – 2007 Application Guidance and Instructions is based on the existing Block Grant legislation, it began the transition toward performance partnerships through a stronger and slightly different emphasis on performance indicators. The existing five (5) criteria are still used to structure State planning efforts, but the 2006-2007 Application places emphasis on the use of the National Outcome Measures (NOMS) formerly called Core Performance Indicators. The FY 2006 – 2007 Application is consistent with past applications in that its intent is to guide States' planning and reporting without placing undue burden upon the States. The Application Guidance and Instructions Packet consist of five parts:

- Part A provides a context and overview of the FY 2006 – 2007 application with a more detailed discussion of the transition to performance partnerships.
- Part B outlines the administrative requirements, fiscal planning assumptions, and other special guidance that is required for submission of the application.
- Part C provides guidance for development of the three sections of the plan, including Description of State Service System, Identification and Analysis of the Service System's Strengths, Needs, and Priorities and Performance Goals and Action Plans to Improve the Service System for adults and children separately.
- Part D gives guidance for preparation and submission of the Implementation Report which is used to describe the extent to which the State has implemented its prior year plan.

- Part E provides guidance on submission of the Basic and Developmental Data Tables from the Uniform Data Reporting System.

There are also several required attachments and several appendices that provide useful resource information needed for the plan.

PART A: CONTEXT AND OVERVIEW OF FY 2006-2007 CMHBG APPLICATION

I. Statutory Authority

Under the authority of the Public Health Service Act (PHS Act)[1] and subject to the availability of funds, the Secretary of the Department of Health and Human Services, through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), awards Block Grants to States to establish or expand an organized community-based system for providing mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). In order for the Secretary to award these Block Grants, States, Territories and the District of Columbia (herein after referred to as States) are required to submit an application, prepared in accordance with the law, for each fiscal year for which the State is seeking funds. The funds awarded are to be used to carry out the State plan contained in the application, to evaluate programs and services set in place under the plan, and to conduct planning, administration and educational activities related to the provision of services under the plan.

Specific authority for requiring data from the States is found in three different Sections of the law. First, the Secretary is required to establish definitions for SMI and SED.[2] Second, in order to receive funding, States will provide to the Secretary any data required pursuant to Section 505, and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section. [3] Third, the application (including the plan under Section 1912(a)), must be otherwise in such form, made in such manner, and contain such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.[4] A grant may be made only if the plan meets the five (5) criteria in the law and is approved by CMHS. [5] After review of the State plan implementation report for the previous fiscal year, CMHS must also determine that the State has completely implemented the plan approved for the previous fiscal year.

1. Sections 1911-1920 and 1941-1954 of the Public Health Service Act (PHS Act)
2 Section 1912(c)(1) and (2) (42 U.S.C. 300x-2)
3. Section 1943(a)(3) (42 U.S. C. 300x-53)
4. Section 1917(a)(7)
5. Section 1912 (b)

II. History and Goals of Federal Mental Health Funding and Planning Requirements

Federal financial support of mental health programs has gone through many transitions from its beginning in 1963 with passage of the Community Mental Health Centers legislation to provide comprehensive services in local communities, [6] through conversion to block grants in 1981, and passage of legislation in 1986 and 1990 requiring states to develop and enhance comprehensive community-based systems of care.[7] In 1992, Congress passed legislation that moved responsibility for administration of the mental health block grant and state planning requirements from the National Institute of Mental Health to the newly formed Center for Mental Health Services, part of the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services. Finally, in 2000, legislative changes allowed states more flexibility in the use of block grant funds. [8]

Over the past 20 years, the evolution of policy changes which tie the mental health block grant funds to the development and implementation of state plans has had the following key goals:

- Access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental and health services, along with mental health services and supports;
- Participation of consumers/survivors and their families in planning and evaluation of state systems;
- Access for underserved populations, including homeless people and rural populations;
- Promoting recovery and community integration of people with psychiatric disabilities; and,
- Accountability through uniform reporting on access, quality, and outcomes of services.

These goals have been reaffirmed in recent years by several key federal developments: the Surgeon General's Report on Mental Health (1999); the New Freedom Initiative for People with Disabilities (2001); and the report of the New Freedom Commission on Mental Health (2003).

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6. Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America*. Princeton, NJ: Princeton University Press, 1991, 113-114.
7. Joseph N. De Raismes, III, *The Evolution of Federal Mental Health Planning Legislation*. http://www.namhpac.org/pages/bckground/back_evolution.html
8. De Raismes, http://www.namhpac.org/pages/bckground/back_evolution.html

These documents emphasize the importance of access to work, housing, rehabilitation, and other services which support integration into the community for people with psychiatric disabilities, as well as the other goals listed above.

The July 2003 Final Report of the President's New Freedom Commission on Mental Health, entitled "Achieving the Promise: Transforming Mental Health Care in America," acknowledges that the public mental health system is in disarray, and does not fulfill the promise of a meaningful life in the community for people with psychiatric disabilities. The Report recommends six broad goals for a transformed public mental health system that would promote recovery:

1) Americans understand that mental health is essential to overall health;
2) Mental health care is consumer and family- driven;
3) Disparities in mental health services are eliminated;
4) Early mental health screening, assessment and referral are common practice;
5) Excellent mental health care is delivered and research is accelerated; and,
6) Technology is used to access mental health care and information.[9]

Each of these major goals has sub-goals; Goal 2, "Mental health care is consumer and family-driven," has as one of its sub-goals a call for more attention to comprehensive state mental health planning, and a call for more accountability, not just to federal funders, but to consumers and families as well.

Recognizing that "in the past decade, mental health consumers have become involved in planning and evaluating the quality of mental health care and in conducting sophisticated research to affect system reform," the Report goes on to recommend that "local, state, and federal authorities must encourage consumers and families to participate in planning and evaluating treatment and support services. The direct participation of consumers and families in developing a range of community-based, recovery-oriented treatment and support services is a priority."[10]

9. The President's New Freedom Commission on Mental Health, 5-6.
10. The President's New Freedom Commission on Mental Health, 18.

III. Planning Initiatives

The release of "Achieving the Promise: Transforming Mental Health Care in America," is the most recent of three significant developments at the national level that have proven to be formative to the planning and development of the future expectations of the Mental Health Block Grant (MHBG) and the development of comprehensive, community-based systems of care for individuals with serious mental illness.

As early as the 1990s, discussions between CMHS and the States began to focus on the federal-state partnership that anticipated the transformation of the CMHS Block Grant from its current emphasis on requirements, earmarks, and accountability based on expenditures, to a system referred to as "performance partnerships". Through this effort, SAMHSA anticipated legislation that would offer States more flexibility in administration of the MHBG while basing accountability on how well the system provided access to quality mental health services for adults with serious mental illness and children with serious emotional disturbance. Accountability would be measured by the appropriateness and outcomes of services based on the collection of standardized data from the States.

SAMHSA is currently finalizing a report requested by Congress on implementing performance partnerships which clarifies that SAMHSA is moving toward increased accountability based on quantitative performance measurement. The NOMS shown in Table 4 that are derived from the Uniform Reporting System (URS), are key features of SAMHSA's plan for increased accountability from the States. The NOMS provide the framework for a national set of uniform outcome measures. These measures (and other measures specific to mental health services as determined by the individual States according to their priorities and needs) will help assess whether mental health services funded by the Community Mental Health Services Block Grant lead to better outcomes for adults with SMI and children with SED. The URS contains a set of basic and developmental tables that have been created in collaboration with States to provide SAMHSA/CMHS a national picture of the public mental health system. Twelve (12) basic tables were introduced in the FY 2002-2004 application. The remaining nine (9) developmental tables, which are in varying stages of development, were added to the FY 2005-2007 application. Both sets of tables are located in Appendices I and II.

In 2003 the Office of Management and Budget (OMB) applied its Program Assessment Rating Tool (PART) to the MHBG program. OMB uses PART to give a numerical rating to measure program purpose, design and effectiveness, with a view to the implementation of performance budgeting. OMB recommended that SAMHSA help States strengthen their ability to assess program results and accountability by: (1) developing targets and measures; (2) conducting program evaluations; (3) linking budget proposals to program performance; (4) sharing performance information with the public; and (5) demonstrating progress in achieving goals. OMB PART required four annual and long-term goals that would measure the efficiency and effectiveness of the MHBG Program.

OMB explicitly recognized that SAMHSA's move toward implementing NOMS will help address these areas of greatest need, as states will be required to report on outcome and other performance data in exchange for additional flexibility. As a result of these developments, the ultimate effectiveness of the national program is directly dependent upon the development and implementation of NOMS and the relationship to the national block grant goals and the employment of reliable data. CMHS and the Division of State and Community Systems Development laid the groundwork for implementing national outcomes by integrating the four performance indicators required by PART into the URS. Additionally, these four NOMS replaced the Government Performance and Results Act (GPRA) indicators that were provided in previous years' plans. This level of integration will enable partners to work towards the annual and long-term goals of the MHBG Program.

The development of increasing accountability and meaningful quantitative outcomes and reliable data has progressed over the last several years. CMHS has worked with the States to enhance a mental health services data system, including the identification and specification of performance measures and collection of a set of basic data. This effort resulted in the CMHS Uniform Reporting System (URS) that contains 21 data tables with various measures of the public mental health services system. The Basic Tables were finalized in the previous application. Collaboration on both refinement and definition of the Developmental Tables has continued with CMHS and the States through ongoing Data Infrastructure Grant (DIG) Workgroups. All of the

tables were developed in collaboration with the States and NASMHPD, and the specific measures and measurement are expected to be reported by the States on a yearly basis in the MHBG Implementation Report. The four measures (1-4) required for the Mental Health Block Grant are all derived from these tables.

These tables also serve as the basis for the (DIG's) that were first offered to States and Territories in FY 2001 to provide funding to improve their data collection activities that would result in reporting uniform data that could be aggregated on a national basis. CMHS, working with the States and Territories, are operationalizing the measures included in the data tables through monthly meetings of CMHS program staff and staff from the States.

All States and Territories that accepted a DIG are required to submit data on the URS tables consistent with the work that has been accomplished in the DIG's including using the uniform definitions and methods agreed to by the States and Territories. Likewise, the measures that States and Territories will use for reporting and planning purposes in their State plans should be consistent with and reflect the data reported in the related URS table. Lastly, as the work progresses under the DIG, States will be expected to begin reporting those items. Instructions and expectations regarding the actual reporting and implementation of NOMS that are currently under development will be transmitted separately.

The data in the URS tables made it possible for CMHS, working with the States and other stakeholders, to develop a list of outcome and performance measures. NOMS for the Mental Health Block Grant Program were identified from this list.

These developments have guided the transformation of this application guidance and instructions, and support CMHS's continued efforts to strengthen its partnership with State Mental Health Authorities (SMHAs) through the administration of the mental health block grant. It is expected that this guidance and instructions will assist States in developing comprehensive plans that describe the State's service system, identify and assess the strengths and challenges within the system, and provide information on NOMS..

IV. Plan Format: Child/Adult Plans; One Year and Multi-Year Plans

Under Section 1912(b) of PHS Act (42 USC 300x-2), the State Plan must address the five (5) legislated criteria. Criteria 1, 2, 4 and 5 must be addressed for adults with SMI, and Criteria 1-5 must be addressed for children with SED. **States should submit a single plan in which services for both adults with SMI and children with SED are addressed separately.** A listing of the **"Criteria to be Addressed in the State Plan"** is shown in Table 3.

States have the option of submitting one or two-year Plans. Guidance for submission of One Year and Two-Year Plans is provided below.

(1) Application Overview for State Plans Beginning in FY 2006

This guidance will be used by all States regardless of whether a State submits a single year or a multi-year plan. In preparing State Plans for FY 2006 (due September 1, 2005), States should use **this** Application Guidance and Instructions. The application must include a Face Sheet, a Table of Contents, an Executive Summary, and all items required in Part B, Part C (Sections I-III). The implementation report (Part D & E), due December 1, 2006, will describe the extent to which the State implemented its mental health plan for FY 2005 and will include data from the Uniform Reporting System (URS Tables).

The plan (Sections I-III) must address each element of the four (4) criteria for adults and five (5) criteria for children as enumerated in the block grant legislation. The plan should contain goals and targets for the NOMS. States that received approval to exclude funds from the maintenance of effort calculation should include those MOE approval documents, as well. If changes occur during the year that affects the plan as submitted to CMHS, States may submit a modification of the Plan to CMHS. States are also reminded that criterion 5 requires information on how the grant will be expended and a funding plan.

(2) Guidance Specific to Two-Year Plans in FY 2006

States submitting two-year plans must ensure that the plan clearly documents goals, targets, and funding plans for each year covered by the plan. The plan must include the following:

- Face Sheet and, Table of Contents, and an Executive Summary
- All items required in Part B
- Part C (Sections I-III)

In Section III, goals and targets should be included for each year covered by the two-year plan. The implementation report, Part D, (due December 1) will describe the extent to which the State implemented its mental health plan for the previous fiscal year and will include data from the Uniform Reporting System (Part E). States that received approval to exclude funds from the maintenance of effort calculation should include those documents as well.

(3) Guidance Specific to Two or Three-Year Plans Submitted in FY 2005

If a two or three-year plan was approved in FY 2005, the State will be required to submit all items in Part B. Under Part C, Section I will not need to be re-submitted unless the State's public mental health system has substantially changed and/or the State Mental Health Agency's authority changes within the State's organizational structure. Only modifications and changes to Sections II and III must be submitted annually with the State's application, and should describe changes in critical gaps and unmet needs, identify significant achievements reflecting progress towards development of a comprehensive community-based mental health system, and document any changes in the original goals and targets. All performance indicator tables must be updated each year to include narrative as needed. States that submitted multi-year plans in 2005 are expected to ensure that their plans are updated to reflect the current status of their mental health systems. It is important that the MHBG Program be notified of changes made in the State's mental health system after the Plan has been submitted through written modification submitted to SAMHSA's Division of Grants Management Office. Before submitting applications each year, States should assess the impact of any positive or negative changes that occurred in the previous year that will affect the State's ability to carry out the proposed plan. If changes are necessary, States may modify the plan as part of the application package (thus modifying the original plan). In modifying previously approved plans, States should identify specific changes referring to page numbers of the original plan, rather than simply making changes to the original plan and resubmitting it. These modifications should be discussed in detail within the context of the affected criteria, goals, and targets and submitted to SAMHSA's Division of Grants Management Office.

PART B. ADMINISTRATIVE REQUIREMENTS, FISCAL PLANNING ASSUMPTIONS, AND SPECIAL GUIDANCE

I. FEDERAL FUNDING AGREEMENTS, CERTIFICATIONS AND ASSURANCES AND REQUIREMENTS

Federal funding agreements, certifications, assurances and other requirements are necessary each year in order for States to receive mental health block grant funds.

(1) FUNDING AGREEMENTS (Attachment A)

Do not retype the Funding Agreement; this may require re-submission of the agreement which could delay the award of funds. The Chief Executive Officer (Governor) or a formal designee must sign the statutory funding agreements, hereby attesting that the State will comply with them. If the funding agreements are signed by a designee, a letter from the Governor authorizing the person to sign must be included with the application.

(2) CERTIFICATIONS – PHS 5161-1 (Attachment B) - (OMB Approval 0920-0428)

Do not retype any of the certifications; this may require re-submission of a certification, which could delay the award of funds.

(a) Debarment and Suspension

A fully executed Debarment and Suspension Certification must be included.

(b) Drug-Free Workplace Requirements

A fully executed certification regarding Drug-Free Workplace Requirements must be included with the application unless the State has an acceptable FY 1997 Statewide or Agency-wide certification on file with the Department of Health and Human Services. Federal regulations regarding these requirements are found in 45 CFR Part 76.

(c) Lobbying and Disclosure

A fully executed Lobbying Certification must be included for all awards exceeding $100,000. This certification must be signed by the Chief Executive Officer of the State (Governor) or his/her formally authorized designee. Additional information about this requirement can be found in 45 CFR Part 93.

Included in the FY 2006-2007 Application Guidance and Instructions is a copy of Standard Form-LLL "Disclosure of Lobbying Activities" and instructions to report lobbying activities.

(d) Program Fraud Civil Remedies Act (PFCRA)

(e) Environmental Tobacco Smoke

(3) ASSURANCES SF 424B (Attachment C) - (OMB Approval 0348-0040)

Do not retype any of the assurances; this may require re-submission of the assurance(s), which could delay the award of funds.

(4) DATA UNIVERSAL NUMBERING SYSTEM (DUNS) NUMBER

A DUNS number is a unique 9-digit number required for all applicants for Federal grants and cooperative agreements, with the exception of individuals other than sole proprietors. The number is used to identify related organizations that receive funding under grants and cooperative agreements, and to provide consistent name and address. The DUNS Number should be entered on the Face Sheet of the State's Plan/Application.

(5) PUBLIC COMMENT ON THE STATE PLAN

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. States should describe their efforts and procedures to obtain public comment on the plan in this section.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED).[11] Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY _____ **Federal FY_____**

State Expenditures for Mental Health Services

Calculated FY 1994	**Actual FY 2004**	**Actual FY 2005**
$ _____	$ _____	$ _____

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the State may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT (MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements.[12] MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

11. Section 1913(a) of the PHS Act
12. Section 1915(b)(1) of the PHS Act

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. [13] States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY _____ **Federal FY_____**

State Expenditures for Mental Health Services

Actual FY 2003	**Actual FY 2004**	**Actual/Estimate FY 2005**
$_____	$_____	$_____

13. Section 1915(b)(2) of the PHS Act

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

IV. Fiscal Planning Assumptions

If final allocation for the Community Mental Health Services Block Grant for the FYs covered by the State plan is not available at the time of the preparation of this application, the intended use of the funds should be based on the amount of allocation made to the State for the prior FY. States should plan to amend the plan once their final allocations for FY 2006 and subsequent years covered by the plan are known, should the final allocations change from the previous FY level. Funds awarded under this Block Grant must be obligated and expended within the two-

year period. For the FY 2006 block grant award, the period is October 1, 2005 through September 30, 2007. States are also required to submit a Financial Status Report (SF 269 Short Form) 90 days after the end of the obligation and expenditure period which is December 31, 2007.

V. Submission Requirements and Due Dates

Please submit an original application plus two copies to Ms. LouEllen M. Rice, Grants Management Officer, Division of Grants Management, OPS, SAMHSA, 1 Choke Cherry Road,, Room 7-1091, Rockville, Maryland 20857 (for overnight/express mail, use zip code "20850". Parts B and C (Sections I, II, & III) of the State plans/applications are due on September 1, 2005, and Parts D (Implementation Report) and E (Uniform Reporting System) are due December 1, 2005. These are statutorily set due dates and waivers cannot be given. [14] If your State application and Implementation Report are not received in the Office of Grants Management by these mandatory dates, it will be impossible for your State to obtain a grant for the year indicated.

Detailed guidance and instructions for each section of this application are provided. Upon request, CMHS will supply a 3.5" MSWord disk containing the application guidance and instructions. The application is available at the SAMHSA web site as www.mhbg.samhsa.gov. With the exceptions of the Federal Agreements, Certifications and Assurances, all parts of the application may be completed electronically and e-mailed to Deborah Baldwin, Project Officer, State Planning and Systems Development Branch, at deborah.baldwin@samhsa.hhs.gov. If the application is sent electronically, the signed original and two copies of Part B, **and** the original Mental Health Planning Council comments signed by the Chairperson, must be submitted to Ms. Rice by the due date. Should you need additional information regarding submission of the application, contact Ms. Rice at (240) 276-1404. Should you have programmatic questions, contact your Federal Project Officer at (240) 276-1760.

It would be helpful to have a copy of each State's plan sent electronically to expedite the Block Grant review process. Copies should be emailed to deborah.baldwin@samhsa.hhs.gov.

14. As required by Section 1917(a)(1) (42USC 300x-6) of the PHS Act

The original and two (2) copies should be submitted unbound, without staples, paper clips or fasteners. Do not attach or include anything folded, pasted, or in a size other than 8½" x11" on white paper. Heavy or lightweight paper should not be used, and submissions should be printed only on one side. Do not condense type closer than 15 characters per inch. Each sheet of the application should be numbered consecutively from beginning to the end (for example, page 1 for the face sheet, etc.). If appendices or additional materials are included, they should be numbered continuing the same sequence. It is recommended that the State plan be limited to 120 pages; if the application exceeds 120 pages and /or is bound, please provide 10 copies.

VI. STATE MENTAL HEALTH PLANNING COUNCIL

(1). Membership Requirements

State Mental Health Planning Councils are required to conform to certain membership requirements. [15] This includes representatives of certain principal State agencies;[16] other public and private entities concerned with the need, planning, operation, funding and use of mental health services and related services; adults who are current or former consumers of mental health services; family members of adults with serious mental illness and children with serious emotional disturbances, and representatives of organizations of individuals with mental illness and their families and community groups advocating on their behalf. Specifically, the law stipulates that not less than 50% of the members of the planning council shall be individuals who are **not** State employees or providers of mental health services. The law also requires that the ratio of parents of children with SED to other members of the Council be sufficient to provide adequate representation of such children in the deliberations of the Council.

(2). State Mental Health Planning Council Membership List and Composition

To demonstrate compliance with the statutory membership requirements, Tables 1 and 2 should be completed for the current fiscal year. In the Table 1 column, "Type of Membership," indicate

15. Section 1914(c) of the PHS Act

16. The principal State agencies are: Mental Health, Education, Medicaid, Vocational Rehabilitation, Housing, Social Services and Criminal Justice.

whether a member is a consumer, a family member of a child with SED, a family member of an adult with SMI, a provider, a state employee, or a representative not otherwise stated in the legislation.

(3). Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties.[17] If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

- reviewing plans and submitting to the State any recommendations for modification
- serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
- monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.[25]
- the role of the Planning Council in improving mental health services within the State.

(4). State Mental Health Planning Council Comments and Recommendations

With the Plan submission, States are required to submit documentation that the State Plan was shared with the Planning Council. Any comments and recommendations to the State plan received from the Planning Council must be submitted, regardless of whether the State has accepted the recommendations. In the annual implementation report, States are also required to submit documentation that the State Plan was shared with the Planning Council and must include any comments from the Council on the State's annual implementation report. The documentation, preferably in a letter signed by the Chair, should indicate that the Council has reviewed the State plan and the annual report as appropriate.

17. Section 1914(b) of the PHS Act (42 U.S.C. 300x-4)

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone & Fax

Additional lines may be added to table as needed.

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP		
Consumers/Survivors/Ex-patients (C/S/X)		
Family Members of Children with SED		
Family Members of Adults with SMI		
Vacancies (C/S/X & family members)		
Others (Not state employees or providers)		
TOTAL C/S/X, Family Members & Others		
State Employees		
Providers		
Vacancies		
TOTAL State Employees & Providers		

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State employee and provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.

PART C. SPECIFIC GUIDANCE FOR STATE APPLICATIONS AND PLANS

SECTION I. Description of State Service System

In this section, States are requested to identify any issues or initiatives within the State that are important in understanding the State plan in the context of the broader system. This section should include:

- An overview of the State's mental health system: a brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
- A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.
- New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
- Legislative initiatives and changes, if any.
- A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.
- A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

SECTION II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

This section should be written primarily in narrative form with separate discussions of services for adults and children. In preparing the discussions, each presentation should be organized so that it follows the five criteria established in law (see Table 3 below). In addition, States should separately address the following:

- A discussion of the strengths and weaknesses of the service system;
- An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them
- A statement of the State's priorities and plans to address unmet needs.

- A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
- A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Table 3. Statutory Criteria to be addressed in the State Plan

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:
  - Health, mental health, and rehabilitation services;
  - Employment services;
  - Housing services;
  - Educational services;
  - Substance abuse services;
  - Medical and dental services;
  - Support services;
  - Services provided by local school systems under the Individuals with Disabilities Education Act;
  - Case management services;
  - Services for persons with co-occurring (substance abuse/mental health) disorders; and
  - Other activities leading to reduction of hospitalization.

Criterion 2: Mental Health System Data Epidemiology

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 3: Children's Services

- Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:
  - Social services;
  - Educational services, including services provided under the Individuals with Disabilities Education Act;
  - Juvenile justice services;
  - Substance abuse services; and
  - Health and mental health services.
- Establishes defined geographic area for the provision of the services of such system.

Criterion 4: Targeted Services to Rural and Homeless Populations

- Describes State's outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals in rural areas

Criterion 5: Management Systems

- Describes financial resources, staffing and training for mental health services providers necessary for the plan;
- Provides for training of providers of emergency health services regarding mental health; and
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

Note: Criteria 1, 2, 4 and 5 must be addressed in the Adult Plan; Criteria 1-5 must be addressed in the Children's Plan

SECTION III: Performance Goals and Action Plans to Improve the Service System

1. Common Requirements for Adult and Child Plans

SAMHSA, in partnership with the States, identified data to be used to develop performance indicators that will increase accountability and demonstrate on a state-by-state basis whether community-based services lead to better outcomes for people served. SAMHSA has identified a set of National Outcome Measures (NOMS) that States are expected to integrate into their Mental Health Block Grant planning process.

This section should be organized in the same way as Section II above, with separate discussions of services for adults and children and organized so that it follows the five criteria. Rather than focusing on strengths, needs and priorities, this section will focus on specific performance goals and action plans. State plans should include a description in narrative form of current activities in the context of the five required criteria (Table 3 above) as well as goals, targets, and action plans for the appropriate criterion using the NOMS (see Table 4 below), as well as any state-specific indicators they may choose. The State information will include specific performance goals and a description of how the State intends to achieve the performance goals. Because some States may not have the capacity to report on all indicators, States may set baseline targets in FY 2006 and begin reporting in FY 2007. States may continue to develop and maintain state-specific performance indicators that they find useful for tracking improvements in the public mental health system. More detailed instructions for incorporating the narrative for the five required criteria and the performance indicators are presented in the instructions for the Adult and Child Plan below.

2. National Outcome Measures

For each of the 5 criteria, States should continue to develop, maintain and report on state-specific performance indicators that they find useful for tracking improvements within the State, in addition to incorporating the NOMS discussed above. States should provide information on these indicators, including specific performance goals, target performance levels, (including delineation of how those targets were established), and a description of how the State intends to achieve those performance goals.

Table 4 Illustrates the National Outcome Measures:

1. The four National Outcome Measures required by the OMB PART. States are expected to incorporate these four measures along with the State-specific indicators in the FY 2006 Plan. In future years, requirements for reporting on the remaining NOMS will be phased in and updated as needed.
2. The location of the four NOMS within the five criteria.
3. The table distinguishes which NOMS are derived from the Basic Tables and Developmental Tables. Those derived from the Developmental Tables will require further collaborative work by SAMHSA and the States to specify and define the measures used to construct them. Once work on a Developmental Table is finalized through the DIG process, it is expected that States will begin reporting data and incorporating the measure into the plan. It is expected that all developmental measures will be finalized by the end of FY 2007.

Table 4 NATIONAL OUTCOME MEASURES (NOMS)

National Outcome Measures		Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS EXPECTED IN 2006 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST *				
1. Increased Access to Services*	Number of Persons Served by Age, Gender, and Race/Ethnicity	Criteria 2 and 3	Basic Tables 2A and 2B	Yes
2. Reduced Utilization of Psychiatric Inpatient Beds*	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days	Criteria 1 and 3	Developmental Table 20A	Yes
3. Use of Evidence-Based Practices*	Number of Evidence-based Practices Provided by State	Criteria 1 and 3	Developmental Tables 16 and 17	Yes
	Number of Persons Receiving Evidence-based Practice Services	Criteria 1 and 3	Developmental Tables 16 and 17	Yes
4. Client Perception of Care*	Clients Reporting Positively About Outcomes	Criteria 1 and 3	Basic Table 11	Yes
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
5. Increase/Retained Employment or Return to/Stay in School	Profile of Adult Clients by Employment Status	Criterion 1	Basic Table 4	No
	Increased school attendance	Criteria 1 and 3	Developmental Table 19C	No
6. Decreased Criminal Justice Involvement	Profile of Client Involvement in Criminal and Juvenile Justice Systems	Criteria 1 and 3	Developmental Table 19A and 19B	No
INDICATORS IN DEVELOPMENT				
7. Increased Social Supports/Social Connectedness	TO BE DETERMINED	Criteria 1 and 3	Developmental TBD	No
8, Increased Stability in Housing	Profile of client's change in living situation (including homeless status)	Criteria 1 and 3	Developmental Table 15	No
9. Improved Level of Functioning	TO BE DETERMINED	Criteria 1, 3, and 4	Developmental TBD	No

***Explanation of National Outcome Measures (NOMS)**

SAMHSA has identified (9) National Outcome Measures (NOMS) for mental health. NOMS 1-4 are required for the Mental Health Block Grant Program to comply with OMB PART. NOMS 1, 4, and 5 are derived from the URS Basic Tables. NOMS 2 , 3, 5, 6, & 8 are derived from the URS Developmental Tables and will require further collaborative work by the DIG workgroups. NOMS 7, & 9 are under development and to be determined. As the DIG workgroups proceed, emphasis will continue to be placed on maintaining consistency in the refinement of NOMS for the Basic and Developmental Tables. In FY 2006, States are expected to report indicators for NOMS 1-4 and encouraged to report on NOMS 5,and 6 if the data are available. *Please note that as the Data Tables are finalized through the DIG workgroups, States are expected to report on these measures.*

States are expected to use State-specific indicators on each of the five criteria along with the NOMS in Table 4 above in the FY 2006 plan. Because some States may not have the capacity to report on all NOMS, States may set baseline targets in FY 2006 and begin reporting in FY 2007. The selection of specific goals and targets for NOMS is determined by each State. States will also determine the goals and targets for State selected performance indicators**.** The goal, targets, and performance indicators should be prepared for each criterion following the one-page sample in Appendix I, National Outcome Measures and State Specific Performance Indicators. For each goal, target and corresponding performance indicator included in the State plan, a similar one-page description employing the same format should be included.

3. Format of Plans

(a) Adult Mental Health Plan

(i) Current Activities

States should describe their adult mental health service system in a narrative that addresses Criteria 1, 2, 4 and 5 of Table 3 above. Narratives for each criterion should convey the extent to which the services required under the criterion have already been implemented. The narrative should discuss implementation strategies to be employed under each criterion and include under criterion 5, plans to organize, finance and deliver services within the community mental health system. Human resources that will be available and necessary to carry out the plan should be identified.

(ii) Goals, Targets and Action Plans

For each criterion, the plan should include goals, targets and action plans which include state specific performance indicators for adults with SMI that are useful for tracking improvements in the public mental health system within the State in addition to the NOMS discussed above. A narrative describing the State's actions toward achieving these improvements must accompany the indicators.

Further description of the construction of the indicators is shown in Appendix I. If States are unable to collect and report the data for any of the tables from which the NOMS are constructed, the State Level Data Reporting Capacity Checklist should be completed or a narrative provided that describes the State's efforts toward building capacity to collect the data and an estimated completion data. However, States are encouraged to complete and include in the plan all indicators that can be constructed from available data in the URS Tables.

For each indicator, States must show the data for the past two years (to the extent that it is available), and project a specific target for the next year (or the next two years for multi-year plans.) The most common table format for presenting indicators is provided below. Accompanying narrative describing actions the State intends to take to achieve each of its goals must also be presented. Further instructions related to preparation of performance indicators are shown in Appendix I.

Performance Indicator Table for State Plan

Name of Performance Indicator:
Population:
Criterion:

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator					
Numerator			---	---	---
Denominator			---	---	---

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g.*, Increased Access to Services)
Population: SED Children or name special population
Criterion: *e.g.*, "Criterion 1, Comprehensive Community-Based Mental Health Service System"
Target: a target is specific, measurable, and expected to be achieved within a defined period of time, and, if attained, is expected to contribute to the realization of the goal
Performance Indicator=Numerator divided by Denominator (except in cases where there is no denominator) and expressed as a percentage.

Columns:
(2) Actual FY2003 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(3) Actual FY2004 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(4) State projected value for this performance indicator for FY2005; **it is not necessary to include the numerator and denominator.**
(5) State target for FY2006; required for single and multi-year plans .
(6) State target for FY2007; required for multi-year plans only.

Columns (5) and (6) are required for states that are submitting multi-year plans.

(b) Children's Mental Health Plan

(i) Current Activities

States should describe their children's mental health service system in a narrative that addresses Criteria 1, 2, 3, 4 and 5 in Table 3 above. Narratives for each criterion should convey the extent to which the services required under the criterion have already been implemented. The

narrative should discuss implementation strategies to be employed under each criterion and include under criterion 5, plans to organize, finance and deliver services within the community mental health system. Human resources that will be available and necessary to carry out the plan should be identified.

(ii) Goals, Targets and Action Plans

For each criterion, the plan should include goals, targets and action plans which include the state specific performance indicators for children with SED that are useful for tracking improvements in the public mental health system within the State in addition to the CMHS Core Performance Indicators discussed above. A narrative describing the State's actions toward achieving these improvements must accompany the indicators.

Further description of the construction of the indicators is shown in Appendix I. If States are unable to collect and report the data for any of the tables from which the CMHS Core Performance Indicators are constructed, the State Level Data Reporting Capacity Checklist should be completed **or a narrative provided that describes the State's efforts toward building capacity to collect the data and an estimated completion data.** . However, States are encouraged to complete and include in the plan all indicators that can be constructed from available data in the URS Tables.

For each indicator, States must show the data for the past two years (to the extent that it is available), and project a specific target for the next year (or the next two years for multi-year plans.) The Table format for presenting each indicator is presented below. Accompanying narrative describing actions the State intends to take to reach each of its goals must also be presented**.**

Performance Indicator Table for State Plan

Name of Performance Indicator:
Population:
Criterion:

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator					
Numerator			---	---	---
Denominator			---	---	---

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g.*, Increased Access to Services)
Population: SED Children or name special population
Criterion: *e.g.*, "Criterion 1, Comprehensive Community-Based Mental Health Service System"
Target: a target is specific, measurable, and expected to be achieved within a defined period of time, and, if attained, is expected to contribute to the realization of the goal
Performance Indicator=Numerator divided by Denominator (except in cases where there is no denominator) and expressed as a percentage.

Columns:
(2) Actual FY2003 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(3) Actual FY2004 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(4) State projected value for this performance indicator for FY2005; **it is not necessary to include the numerator and denominator.**
(5) State target for FY2006; required for single and multi-year plans .
(6) State target for FY2007; required for multi-year plans only.

Columns (5) and (6) are required for states that are submitting multi-year plans.

PART D. Implementation Report

This section will contain the State Plan Implementation Report for FY 2006 as required by the PHS Act[18] States are requested to prepare and submit their implementation reports for the last completed FY in the format provided in this guidance. This will contain a report on the purposes for which the Community Mental Health Services Block Grant monies were expended, the recipients of grant funds, and a description of block grant-funded activities.[19] The report shall focus on the extent to which the State has implemented its plan for the FY, with particular attention given to the goals and performance indicators. This section should also contain any comments from the mental health planning council, preferably in the form of a letter.[20] The Data Tables (presented in Part E) are considered a component of the Implementation Report. Please submit an original implementation report plus two copies to Ms. LouEllen M. Rice, Grants Management Officer, Division of Grants Management, OPS, SAMHSA, 1 Choke Cherry Road, Room 7-1091, Rockville, Maryland 20857 by December 1, 2006. As noted above, electronic submissions are allowed and should be mailed to Deborah Baldwin, Project Officer, at deborah.baldwin@samhsa.hhs.gov. If an electronic copy is submitted, two additional hard copies mentioned above must also be mailed to the Grants Management Office. Please note that if your Implementation Report is not received in the Office of Grants Management by December 1, your State will not obtain a grant for the year indicated.

I. Narrative Content of the Implementation Report

1) Report Summary

- Areas which the State identified in the prior FY's approved Plan as needing improvement;
- The most significant events that impacted the mental health system of the State in the previous FY; and
- A report on the purposes for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

18. Section 1912(d)(1) of PHS Act (42 USC 300x-2)
19 As required by Section 1942(a)(1) and (2) of PHS Act (42 U.S.C. 300x-52).
20 As required by Section 1915 (a)(2) of PHS Act.

II. Performance Indicators

1) **Performance Indicators.** States are required to complete the Performance **Indicator Table for the Implementation Report** as presented below**.** The purpose of this table is to show data for the State-selected performance indicators and the CMHS NOMS over time. Narrative discussion of performance indicators (see discussion in Section IV). should be provided with these tables.

Performance Indicator Table for Implementation Plan

Name of Performance Indicator:
Population:
Criterion:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2005 % Attained	FY 2006 Target	FY2006 Actual	FY 2006 % Attained	FY 2007 Target
Performance Indicator							
Numerator			---	---		---	---
Denominator			---	---		---	---

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g.*, Increased Access to Services)
Population: SMI Adult or SED Children or name special population
Criterion: *e.g.*, "Criterion 1, Comprehensive Community-Based Mental Health Service System"
Target: a target is specific, measurable, and expected to be achieved within a defined period of time, and which, if attained, is expected to contribute to the realization of the goal
Performance Indicator: Numerator divided by Denominator (except in cases where there is no denominator) and expressed as a percentage.

Columns:
(2) Actual FY2004 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(3) Actual FY2005 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(4) Percentage attained for indicator in FY 2005
(5) State Target for FY 2006
(6) Actual FY2006 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(7) Percent attained is equal to dividing column (6) by column (5). If less than 100%, State did not achieve its target; if greater than 100%, State surpassed its target.
(8) State Target for FY 2007

III. Accomplishments

This section should be integrated with the data presentation above. For each of the targets and corresponding performance indicators, the State should provide a brief narrative containing the following information:

- Documentation of the activities under each indicator for each criterion. This shall include data to support the State's report about its accomplishments for each target and performance indicator identified in the Plan for the prior FY.
- Description of activities and strategies the State used to address the performance indicator;
- Any changes in the implementation strategy described in the Plan for the prior State FY;
- Any innovative or exemplary model of mental health service delivery that the State developed, and its unique features;
- At the end of each indicator's narrative, the report should clearly state whether or not the particular target identified in the Plan for the prior State FY for adults with SMI or children with SED was "achieved" or "not achieved"; and
- If the targets were "not achieved," explain why.

PART E: Uniform Data on Public Mental Health System

This section guides States in the reporting of uniform data on public mental health services in the State (with special focus on community mental health services) in a series of basic and developmental data tables. The completion of Part E is a term and condition for funding for States and Territories that were awarded Data Infrastructure Grants; all States and Territories that accepted the grant agreed to submit Part E as part of the FY 2006 Implementation Report. The Report for FY 2006 is due December 1, 2006 with Part D, the Implementation Report. States and Territories that did not receive a Data Infrastructure Grant are encouraged to submit data under Part E. If a State cannot provide data in tables, the State must indicate its reporting capacity in the State Level Data Reporting Capacity Checklist. To ensure uniformity, the data reported shall be based on the data definitions agreed to in the Mental Health Data Infrastructure Project. States are requested to report data based on the last completed fiscal year.

Uniform data on the public mental health system are required to improve planning and oversight of community mental health services provided under the Community Mental Health Services Block Grant and Performance Partnerships. Block grant funds further the capacity of the publicly funded community mental health system in each state. The flexible funding of the block grant allows States to fund gap-filling, new and innovative services. To understand the value and usage of block grant funds, it is critical that both CMHS and the State Mental Health Authorities (SMHAs) have accurate and uniform data on the public mental health system in each State. Towards this end, the data requested in the tables described in this Section answer five basic questions: 1) What are the mental health service needs of the population in your State? 2) Who in your State gets access to publicly funded mental health services? 3) What types of services are being provided in your State? 4) What are the outcomes of the services provided? and 5) What financial resources are expended for the services?

All client data will be aggregated at the State level. No individual client data are requested or should be submitted. State identifiers are required for each table. CMHS, working with its contractor, the National Association of State Mental Health Program Directors (NASMHPD) National Research Institute (NRI), will create all derived measures from the primary data provided by the States. CMHS will review the State-submitted data and make requests for

revision, clarification, or additional information as appropriate from the State MHAs. After the final review and analysis of the data is completed, CMHS will make State-by-State data profiles available, as well as summary tables that examine performance across all States for selected data elements.

ATTACHMENTS

A. Federal Funding Agreements
B. Certifications
C. Disclosure of Lobbying Activities
D. Assurances
E. Face Sheet

APPENDICES

I. Format for Constructing and Reporting Performance Indicators
II. Format for the Table of Contents

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2006

I hereby certify that _____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[21] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2006, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

21. The term State shall hereafter be understood to include Territories.

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:
(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.
(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date

B. Certifications
http://www.mhbg.samhsa.gov/certification.pdf

C. Disclosure of Lobbying Activities
http://www.mhbg.samhsa.gov/disclosure.pdf

D. Assurances
http://www.mhbg.samhsa.gov/assurance.pdf

Attachment E **FACE SHEET**

FISCAL YEAR/S COVERED BY THE PLAN

___FY 2006 _____ FY 2006 - 2007

STATE NAME: _____

DUNS #: _____

I. AGENCY TO RECEIVE GRANT

AGENCY: _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: _____ TITLE: _____

AGENCY _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____STATE:_____ ZIP: _____

TELEPHONE: _____ FAX: _____

III. STATE FISCAL YEAR

FROM: _____ _____ TO: _____ _____

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME:_____ TITLE:_____

AGENCY: _____

ORGANIZATIONAL UNIT:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ ZIP: _____

TELEPHONE: _____ FAX: _____ EMAIL: _____

Appendix I. Format for Constructing and Reporting Performance Indicators

As described in PART C: Section III of the State Plan Guidance, in submission of the State's MH Plan, States are expected to continue to develop, maintain and report on state specific performance indicators that are useful for tracking improvements in the public mental health system within the State, in addition to incorporating the set of CMHS NOMS discussed in Section III.

The purpose of this section is to describe the construction and reporting of both types of performance indicators. The section begins with a sample table to be employed with the State Plan and a sample table to be used with the Implementation Report.

Sample Performance Indicator Table for State Plan

Name of Performance Indicator: Percentage of Inpatient Readmissions at 30 days (Reduced Utilization of Psychiatric Inpatient Beds)
Population: Adult SMI
Criterion: Criterion 1: Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	20%	20%	15%	15%	15%
Numerator	2,000	2,000	--	--	--
Denominator	10,000	10,000	--	--	--

This table indicates that:

Column (2) in FY2003, there were 2,000 adults who were readmitted within 30 days out of 10,000 persons discharged from a State Hospital during the past year. That yields a performance indicator of 20% readmitted.

Column (3) For FY2004 the same number of readmissions and discharges occurred resulting in a performance indicator of 20%.

Column (4) For FY 2005, it is projected that 15% of adults discharged from a State Hospital will be readmitted within 30 days.

Column (5) For FY 2006 a target of 15% is set.

Column (6) State target of 15% set for FY2007; required for multi-year plans only.

Sample Performance Indicator Table for Implementation Plan

Name of Performance Indicator: Percentage of Inpatient Readmissions at 30 days (Reduced Utilization of Psychiatric Inpatient Beds)
Population: Adult SMI
Criterion: Criterion 1: Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2005 % Attained	FY 2006 Target	FY2006 Actual	FY 2006 % Attained	FY 2007 Target
Performance Indicator	20%	20%	100%	15%	15%	100%	12%
Numerator	2,000	2,000	---	--	1,500	---	
Denominator	10,000	10,000	---	--	10,000	---	

This table indicates that:

Column (2) in FY2004, there were 2,000 adults who were readmitted within 30 days out of 10,000 persons discharged from a State Hospital during the past year. That yields a performance indicator of 20% readmitted.

Column (3) For FY2005 the same number of readmissions and discharges occurred which resulted in a performance indicator of 20%.

Column (4) the percentage attained was 100% as reported in the FY 2005 Implementation Report

Column (5) For FY 2006, a target of 15% readmitted was set

Column (6) For FY 2006 1,500 readmissions occurred out of 10,000 discharges resulting in a performance indicator rate of 15%

Column (7) For FY 2006 the State met 100% of its goal (Column (6) divided by column (5).

Column (8) For FY 2007 a target of 12% was set (only if a multi-year plan was submitted)

Immediately following the table, there should be narrative discussion indicating whether the results are satisfactory or what actions the State plans to take to improve performance on this indicator in the future

1. CMHS NOMS

All but the developmental NOMS may be derived from the Basic or Developmental Data Tables (See Table below).. If States are unable to collect and report the data for any of the tables from which the NOMS are constructed, the State Level Data Reporting Capacity Checklist should be

completed **or a narrative provided that describes the State's efforts toward building capacity to collect the data and an estimated completion data.** . However, States are encouraged to complete and include in the plan all indicators that can be constructed from available data in the URS Tables.

Sources of NOMS in Basic and Developmental Data Tables.

Adult NOMS		**Table Reference**	**Numerator**	**Denominator**
1. Increased Access to Services	Adults served by gender and race/ethnicity	Basic Table 2A	Persons served over the age of 18 by gender, race/ethnicity and total.	NONE
2. Reduced utilization of psychiatric inpatient beds	Decreased rate of readmissions to State Psychiatric Hospitals within 30 days	Developmental Table 20A	Number of persons, aged 18+, who are readmitted to a State hospital within 30 days	Number of persons, aged 18+, discharged from a State Hospital during the past year
	Decreased rate of readmissions to State Psychiatric Hospitals within 180 days	Developmental Table 20A	Number of persons, aged 18+, who are readmitted to a State hospital within 180 days	Number of persons, aged 18+, discharged from a State Hospital during the past year
3. Evidence-based practices	Actual evidence-based practices provided in State	Developmental Tables 16-17	For each of eight evidence-based practices, indicate (Yes-No) whether it being provided	NONE
	Number of SMI adults receiving evidence-based practices	Developmental Tables 16-17	Number of SMI adults, aged 18+, who are receiving any of the eight evidence-based practices	NONE
4. Client Perception of Care	Clients reporting positively about outcomes	Basic Table 11	Number of positive responses reported in the outcome domain on the adult consumer survey	Total responses reported in the outcome domain on the adult consumer survey
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
5. Increase/ Retained Employment or Return/Stay in School	Profile of Adult Clients by Employment Status	Basic Table 4	Number employed	Number employed plus number unemployed
6. Decreased Criminal Justice Involvement	Profile of Client Involvement in Criminal Justice System	Developmental Table 19A	Total C (number with criminal justice involvement)	Total B (number for whom data are available)

Child NOMS		Table Reference	Numerator	Denominator
1. Increased Access to Services	Children served by gender, and race/ethnicity.	Basic Table 2A	Persons served under the age of 18 by gender, race/ethnicity and total.	NONE
2. Reduced utilization of psychiatric inpatient beds	Decreased rate of readmissions to State Psychiatric Hospitals within 30 days	Developmental Table 20A	Number of persons, aged 0-17, who are readmitted to a State hospital within 30 days	Number of persons, aged 0-17 , discharged from a State Hospital during the past year
	Decreased rate of readmissions to State Psychiatric Hospitals within 180 days	Developmental Table 20A	Number of persons, aged 0-17, who are readmitted to a State hospital within 180 days	Number of persons, aged 0-17 , discharged from a State Hospital during the past year
3. Evidence-based practices	Actual evidence-based practices provided in State	Developmental Tables 16-17	Indicate whether therapeutic foster care is being provided.	NONE
	Number of SED children receiving evidence-based practices	Developmental Tables 16-17	Number of SED children, aged 0-17, who are receiving therapeutic foster care	NONE
4. Client Perception of Care	Clients reporting positively about outcomes	Basic Table 11	Number of positive responses reported in the outcome domain on the child consumer survey	Total responses reported in the outcome domain on the child consumer survey
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
5. Increase/Retained Employment or Return to/Stay in School	Increased school attendance	Developmental Table 19C	Total C (number attending school)	Total B (number for whom data are available)
6. Decreased Juvenile Justice Involvement	Profile of Client Involvement in Juvenile Justice System	Developmental Table 19B	Total C (number with juvenile justice involvement)	Total B (number for whom data are available)

2. State Developed Performance Indicators

Over the past years, states have been required to develop state-specific indicators for each of the criteria for the adult and child plans. For this application, they are expected to continue to report on performance indicators that they have considered being important in tracking the progress of the public mental health system in the past, to develop new indicators, as appropriate, as well as incorporating the NOMS.

3. Administrative Goals, Targets and Indicators

Not all goals set by a State need to be immediately associated with service delivery. Some may be related to changes in the structure of the administration of the public mental health system. For example, State mental health authorities may wish to develop a mechanism to pool or blend funding for children's mental health services under the jurisdiction of multiple State and/or local government agencies, in order to promote the reallocation of resources from State inpatient care to community-based services. For objectives identified under such goals, the performance indicator might be an interagency memorandum of agreement, new statutory authority conferred by the Legislature and the Governor, or changes in regulations or contracting procedures.

States are also expected to set administrative goals and targets and to select performance indicators appropriate to them. They should be included within the most appropriate of the mental health block grant criterion. No special format is offered here. States can adapt the format for describing quantitative performance indicators for this purpose.

4. Description of Indicators

The performance indicator tables presented above should be employed to present both plans and results. The guidance below is intended to assure a common approach to describing these indicators. In addition to the performance indicator table, for each indicator there must be a fuller, more descriptive title, as well as other information about the design of the performance indicator. It is to be included following the "Format for Performance Indicator Description," presented below . This description should cover the following elements (see examples below):

- The goal of the State plan under each criterion;
- Specific, measurable objective(s) identified to reach the goal;
- The relevant population group (SMI or SED);
- The relevant mental health block grant criterion;
- Brief name for the indicator;
- Full, descriptive indicator;
- Description of the measure(s) employed to construct the indicator (i.e., contract reporting system, Medicaid claims data, recipient survey);
- Explanatory note, if any;

- Sources of information employed to obtain data for the indicator (i.e., contract reporting system, Medicaid claims, recipient survey);
- Special issues, if any; and
- Significance of the identified objective for the Community Mental Health Services program; please explain the importance of this indicator in impacting on the state system of care.

Examples of Format for Performance Indicator Description

Criterion 1 - Example A

Goal: To significantly reduce the inpatient census of State and county-operated mental health specialty facilities by placing all eligible individuals with mental illness appropriately in the community.

Target: Reduction in inpatient census of State and county operated mental health specialty facilities by another fifty individuals from the current level.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: State & county inpatient census.

Indicator: Number of patients-in-residence in State and county hospitals among persons who are SMI or SED.

Measure: This number may be either (1) the number of patients who are in residence in State and county mental health specialty hospitals at the end of the State's fiscal year OR (2) the average daily inpatient census for the State's fiscal year.

NOTE: If the State contracts out for care that formerly would have been provided in its inpatient system, patients-in-residence or daily average census for these contracts should be incorporated and explained on this indicator page. Separate performance indicators should be maintained for adults and for children. For adults, States should indicate whether forensic inpatient information is included in the total. In some states it may be appropriate to focus on inpatients with a civil commitment status only.

Sources(s) of Information: State hospital reporting system; contract reporting system.

Special Issues: In many States, reduced utilization of State hospital care may be the result of expanded utilization of general hospital psychiatric inpatient beds, particularly by persons who are eligible for Medicaid and Medicare. States may wish to track utilization of psychiatric inpatient care under these and other auspices. This indicator would not include persons served in residential treatment facilities. States may wish to track this utilization separately or include it under the indicator percentage of children with SED who are placed out-of-home (e.g., foster care, residential home, juvenile detention).

Significance: A major outcome of the development of a community-based system of care is expected to be reduced utilization of state and county-operated psychiatric inpatient beds.

Criterion 1 - Example B

Goal: To provide case management services for all persons who receive substantial amounts of public funds or services.

Target: Expansion of access to case management services among persons who receive substantial amounts of public funds or services by 5%.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Percentage receiving case management.

Indicator: Percentage of adults with serious mental illness who receive case management services among those who receive substantial amounts of public funds or services.

Measure: Numerator: The number of adult recipients with a serious mental illness who are receiving case management services during the fiscal year.

Denominator: The number of adults who receive a substantial amount of mental-health related public funds or services during the fiscal year.

Sources of Information: Contract reporting system, Medicaid management information system, SMHA client information system, and estimates of treated prevalence.

Special Issues: States must define key terms. The count of persons receiving case management might include only those enrolled in formal case management programs, or might

extend to those who receive case management services in any program which offers those services in conjunction with other mental health services. States must also operationally define the concept of "adults who receive substantial amount of mental-health related public funds or services during the fiscal year". This definition will depend upon what information is most readily available to the State.

Significance: Assuring access to case management services for persons with a serious mental illness is a primary goal of the mental health block grant legislation.

Criterion 1 - Example C

Goal: To provide assertive community treatment to all eligible individuals who request it.

Target: An increase of 40 in the number of persons receiving assertive community treatment (ACT).

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based health system.

Brief Name: Persons receiving ACT.

Indicator: The number of persons receiving assertive community treatment during the fiscal year.

Measure: Count of persons receiving services through a formal ACT program.

Sources of Information: Contract reporting, Medicaid management information system

Significance: Research evidence supports the development of ACT programs to meet the needs of persons with serious mental illness.

Criterion 2 - Example:

Goal: Expand access to mental health services for all persons who have a serious mental illness.

Target: Expansion of access to mental health services to 4% more of the population of persons with a serious mental illness.

Criterion: Prevalence and treated prevalence of mental illnesses

Population: Adults with a serious mental illness.

Brief Name: Treated prevalence of serious mental illness.

Indicator: The percentage of adults with a serious mental illness who receive mental health services during the fiscal year.

Measure: Numerator: Estimated number of adults with a serious mental illness and who have received mental health services during the fiscal year.

Denominator: Estimated number of adults who annually have a serious mental illness in the State.

Sources of Information: Numerator: State client information system, Medicaid management information system.

Special Issues: States may use the CMHS definition for "serious mental illness" and "serious emotional disturbance," and estimates of "prevalence" as an appropriate basis for planning in the public mental health system. If States adopt an alternative definition and a different estimate of prevalence, both the definition and prevalence estimation method should be carefully described and well-justified

Significance: Setting quantitative goals for the number of adults with a serious mental illness to be served in the public mental health system is a key requirement for the mental health block grant legislation.

Appendix II. Format for Table of Contents

TABLE of CONTENTS
STATE BLOCK GRANT APPLICATIONS and Plans

iii. Children's services
iv. Targeted services to rural and homeless populations
v. Management systems

2) Goals, Targets and Action Plans

Part D. Implementation Report

I. Narrative Content of the Implementation Report
II. Performance Indicators
III. Accomplishments

Part E. Uniform Data on Public Mental Health System

Basic and Developmental URS Tables

Attachments

A. Federal Funding Agreements
B. Certifications
C. Disclosure of Lobbying Activities
D. Assurances

Basic and Developmental Data Tables

The URS Basic & Developmental Tables, Guidelines, and Data Definitions for 2005 Reporting are posted in Excel and Word versions on the SDICC site (http://www.nri-inc.org/SDICC/defsdicc.cfm). You will also find the 2005 Data Reporting Capacity Checklist on this site.

The only changes for 2005 not included on the 2005 tables are the EBP guidance on reporting that the EBP workgroup has been developing. This guidance will not change the definitions, but will provide more instructions and examples of when to count a state's service as an EBP service. The additional EBP guidance will be sent to states as soon as they are final.

You will also find on the SDICC website the SMI and SED Prevalence Estimates that have been updated using the latest U.S. Census Bureau population data. These are used for URS Table 1 and may be helpful in completing the MHBG Application.